HYDRONEPHROSIS.*

Dr. M. Krotoszyner reported a case of left-sided hydronephrosis in a man 41, who had suffered for the last few years from intermittent attacks of left-sided renal colic. The urine at times showed albumen, some pus cells and many hyalin and granular casts. The cystoscopical examination presented a normal bladder and upon ureteral examination the left renal secretion showed pus cells and casts. Functional tests showed only a slight deterioration of function on the left side. X-Ray plates were negative for stone-shadows. With these findings the diagnosis of unilateral nephritis seemed to be most plausible, while the differential diagnosis hovered between that and intermittent hydronephrosis of probably mechanical origin, crossing of ureter by aberrant renal vessel. A correct interpretation of the case was finally only possible by pyeolography. Pyeolography was made by means of a 25% solution of cargentos. The plate on the left side showed a large pelvis and below that a round, large shadow representing a cavity at the lower kidney-pole filled with cargentos solution. The patient experienced a quite severe local reaction from the injection of cargentos and voided dark urine for several days afterwards which, upon chemical examination, showed the presence of silver. Proceeding, therefore, from the supposition that the kidney still contained considerable amounts of cargentos a second pyeolography was performed five days after the first one without further injection of cargentos. The second picture showed a beautiful cast of the renal pelvis, calices and the lower-kidney pole permitting the exact recognition of pyo-hydronephrotic foci in the kidney. Upon removal of the kidney this diagnosis was confirmed and the cavities in the removed organ corresponded exactly with the shadows of the second plate.

The patient made an uneventful recovery.

CASE REPORTS.*

DR. HENRY J. KREUTZMANN.

Case No. 1. Large Gallstone. Woman of 64 years, mother of a number of children, always been in good health. One and a half years ago was taken with severe colic pains all over the abdomen, obstruction of bowels, vomiting; no physician in attendance; upon resort to different purgatives bowels moved freely and she was relieved. Has been in good health since until a short time ago when she was again seized with colic pains, obstruction of bowels and vomiting; finding no relief from her own agencies I was called. Abdomen was very large, fat, not painful to touch anywhere. There was no rise of temperature, pulse good. Bowels not entirely closed. When her condition did not improve and the possibility of operative interference had to be discussed, Dr. Conrad Weil was called in consultation. No resort to operation as yet was considered advisable. Next day the nurse in giving a high enema came upon a very hard body in the rectum, which she was able to work out. Dr. Weil says it is a large gallstone, filling out the entire lumen of the bladder, which through usure had worked itself into the intestinal tract.

Case No. 2. Large koprolith, simulating fibromyoma uteri. A young woman from the country was sent to the German Hospital supposedly suffering from a large fibromyomata uteri. Dr. Draper put her under ether for examination and at that time I saw her first. Her previous history was that she had no hemorrhage, but had noticed an enlargement of her abdomen; bowels difficult to move; on one or two occasions she had appendical affection. The abdomen was enlarged, enlargement due to a spherical, hard, slightly movable mass, filling out abdomen, reaching above midway between symphysis pubis and navel, situated mostly in left side, emanating apparently from the left side of fundus uteri, uterus pressed down and backward. The diagnosis of fibromyoma uteri seemed almost established; as a matter of habit after the vaginal examination I put a cover over my left index finger and introduced it into the rectum. I felt a hard mass, was able to remove a little of it; then with plenty of warm water the whole "tumor" was either dissolved or softened and dislodged into the pail. Care was taken for the next few days to have the bowels freely moved. Then some time afterwards finding the uterus still low and retroverted and on account of the attacks of appendicitis we decided to operate. We performed what I take the liberty to call "Kreutzmann's operation," transverse division of the skin (Küstner) and combination of abdominal work (removal of appendix in our case) with extra inguinal shortening of the round ligaments after Alexander. We found the colon and sigmoid enormously enlarged, but no sacculation; all the layers of the intestinal wall taking part in the thickening. Later reports are to the effect that the woman remains well. Dr. Terry reported a year ago some similar cases; this is the first of such large accumulation of feces in my practice.

Cases No. 3 and No. 4. Two cases of ectopic pregnancy. Both women presented typical cases; young women, 1 child, then an attack of pelvic affection, invalidating them for some time, no pregnancy for 6-8 years, then again pregnancy. In the first case the woman was seized with severe pains in right side and slight collapse. Her physician diagnosed ruptured tubal pregnancy and sent her to the German Hospital. I saw her late in the night; no signs of collapse any more, slight pain only; a hard spherical mass on right side of uterus could be distinctly made out. My diagnosis was ovarian kystoma with twisted pedicle, possibly uterine pregnancy. When the abdomen was opened the next day the right tube was found the seat of a pregnancy, fetus found, tube ruptured, slight hemorrhage in abdominal cavity, besides an ovarian kystoma the size of a small orange with long twisted pedicle was found. This case is reported for its extreme rarity. Removal of right adnexa and uninterrupted recovery.

In the second case the first collapse occurred same afternoon, patient of Dr. Max Salomon. The diagnosis seemed well founded merely from the history of her general condition. Woman extremely nervous and sensitive, impossible to make any physical examination. Advice given to go to a hospital, not accepted until next day, when she entered the German Hospital. By that time pain and collapse had entirely ceased; in a few days she went home again. Just two weeks later another attack, more severe this time; the same delay to enter the hospital and much objection to operation. Finally almost in articulo mortis operation performed. Left tube the seat of a pregnancy, ruptured, still bleeding, the abdomen full of blood. Left adnexa removed; recovery. This case is reported merely to show the difficulty under which so much of our work has to be done. It sounds very good to say "Operate when you have a ruptured, bleeding tubal pregnancy." But if the patient or her people do not accept our advice? To give up the case means only to turn it over to some one eager to get a hold of it. We have to take the chances, but cases of this sort demonstrate the necessity of the spirit of solidarity amongst practitioners—alas lacking in so many!

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